



## STATE OF TENNESSEE GROUP INSURANCE PROGRAM

## ENROLLMENT/CHANGE APPLICATION — LOCAL GOVERNMENT PLAN

State of Tennessee • Department of Finance and Administration • Benefits Administration

26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

See back for complete instructions. You must sign and date this form, even if refusing coverage. Please print clearly.

**Part 1—Enrollment or Change Request (check all that apply)**

<b>ADD</b> <input type="checkbox"/> Health <input type="checkbox"/> Dental  <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible Employee <input type="checkbox"/> Special Enrollment Provision <input type="checkbox"/> Medical Underwriting  <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)  Effective _____	<b>CHANGE</b> <input type="checkbox"/> Name and/or Address <input type="checkbox"/> Marital Status <input type="checkbox"/> Health Plan* <input type="checkbox"/> Dental Plan* <input type="checkbox"/> Type of Health Coverage* <input type="checkbox"/> Type of Dental Coverage*  *indicate change in Part 4  Date of change _____	<b>TERMINATE</b> <input type="checkbox"/> Coverage: self <input type="checkbox"/> Coverage: spouse <input type="checkbox"/> Coverage: child  <b>PLAN</b> <input type="checkbox"/> Health <input type="checkbox"/> Dental  Termination Date _____	<b>REASON</b> <input type="checkbox"/> Terminate employment <input type="checkbox"/> Employee request <input type="checkbox"/> Divorce <input type="checkbox"/> Child age <input type="checkbox"/> Child married <input type="checkbox"/> Child no longer student <input type="checkbox"/> Child no longer claimed on federal income tax <input type="checkbox"/> Death
--	--	---	---

**Part 2—Employee Information (must be completed, even if refusing coverage)**

Last Name		First Name		MI	SSN	Date of Birth
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Employee ID (if known)		Employing Department		
Home Address		City	State	Zip Code	County	
If your spouse is a participant in the state group insurance program, provide the following:		Spouse Name		SSN	Department	

**Part 3—Dependent Information (see back for definitions, attach a separate sheet if necessary)**

Social Security Number	Name Last, First, MI	Birthdate mm/dd/yy	Relationship	Gender	Acquire date	Student (age 19-24)	Coverage	
							Health	Dental
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N		
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N		

If your dependents (spouse and children) reside at an address other than yours, please provide this information on an attachment.

**Part 4—Enrollment Information**

<b>HEALTH</b> <input type="checkbox"/> POS <input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West <input type="checkbox"/> PPO <input type="checkbox"/> PPO Limited <input type="checkbox"/> HMO* <input type="checkbox"/> Memphis <input type="checkbox"/> Nashville <input type="checkbox"/> East TN	<b>COVERAGE TYPE</b> <input type="checkbox"/> Single <input type="checkbox"/> Family	<b>DENTAL</b> <input type="checkbox"/> Prepaid* <input type="checkbox"/> PPO	<b>COVERAGE TYPE</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more
---	--	--	--

\*Additional form needed. Please contact your agency benefits coordinator.

**Part 5—Authorization**

☐ **ACCEPT** I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage. I authorize health care providers to furnish the insurance carrier with all medical, admission, and insurance records pertaining to me and my dependents. I understand that if my dependent(s) become ineligible for coverage that I must report the change to my benefits coordinator within five working days. I understand that all claims paid for ineligible dependents will be recovered. As the policy holder, I am responsible for claims payments to my ineligible dependents.

☐ **REFUSAL** I have been given the opportunity by my employer to apply for the group insurance program and after due consideration, have decided *not to take advantage of this offer*. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special enrollment provision or prove insurable through medical underwriting. I understand that the state does not have an open enrollment period for health coverage.

I am currently enrolled in another health insurance plan: ☐ Yes ☐ No

A certificate of coverage letter must be provided to be exempt from the preexisting condition requirement.

I acknowledge receipt of my insurance handbook and accept all the terms and conditions contained therein.

Employee Signature	Date	Work Phone	Home Phone
--------------------	------	------------	------------

**OFFICIAL USE ONLY—TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR (active employees only)**

Original Hire Date	Coverage Begin Date	Reason	County of Work
Benefit Coordinator Signature		Phone	Date

**OFFICIAL USE ONLY—TO BE COMPLETED BY BENEFITS ADMINISTRATION**

Employee ID	Class	Pay Group	Position Number	Annual Salary
-------------	-------	-----------	-----------------	---------------